State:	*District of Columbia*	***Filing Company:***	*New York Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Group Life Insurance Application*		
Project Name/Number:	*/*		

Filing at a Glance

Company:	New York Life Insurance Company
Product Name:	Group Life Insurance Application
State:	District of Columbia
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	11/07/2016
SERFF Tr Num:	NYAA-130732267
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	
Implementation Date Requested:	
Author(s):	Gina Babka
Reviewer(s):	John Rielley (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Association
Filing Status Changed: 11/10/2016
State Status Changed:
Created By: Gina Babka
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Gina Babka

Filing Description:

GPA-A8.1 is an enrollment form used by applicants to enroll for insurance under the AARP Group Life Insurance Program. This is a new form and does not replace any previously approved enrollment form. Similar forms were approved under filing # NYAA-130411370 on April 16, 2016.

The Program, underwritten by New York Life, provides life insurance under various Group Life Insurance policies delivered to the policyholder, AARP, sitused in the District of Columbia. The group policies of the Program are issued on New York Life's Group Life and Accident and Health Policy and Certificate forms, GMR series, previously approved by the Department on November 13, 1989. The forms were subsequently filed and approved for delivery in and outside the District of Columbia.

In addition to a written signature, the enrollment form may be signed by electronic signature or voice signature. The insured will receive a copy of the enrollment form with the certificate. The enrollment form will conform to the documentation with the approved filing. Other approved enrollment forms may be used as applicable.

New York Life intends to use all distribution channels to market these forms.

For administrative purposes, the information on the form is “boxed”. The boxing of information allows New York Life flexibility as far as format and layout is concerned. Boxing also allows the same form to be used for enrollment in other life insurance products that are available under the Program. Please refer to the enclosed Explanation of Variable for Form GPA-A8.1.

If you need additional information, please let me know.

We look forward to your early review and acceptance of this submission. Thank you for your cooperation in this matter.

Sincerely yours,

Gina Babka
Contract Manager
Tel # (800) 595 3869, ext. 5717;
Fax # (813) 288 5773; or
E-mail address: Gina_Babka@NYLAARP.newyorklife.com

Company and Contact

Filing Contact Information

State:	*District of Columbia*	***Filing Company:***	*New York Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Group Life Insurance Application*		
Project Name/Number:	*/*		

Gina Babka, Compliance Consultant
5505 West Cypress Street
Tampa, FL 33607

Gina_Babka@NYLAARP.newyorklife.com
813-288-5717 [Phone]
813-288-5773 [FAX]

Filing Company Information

New York Life Insurance Company
5505 West Cypress Street Suite 300
Tampa, FL 33607
(813) 288-5717 ext. [Phone]

CoCode: 66915
Group Code: 826
Group Name:
FEIN Number: 13-5582869

State of Domicile: New York
Company Type:
State ID Number:

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

State: *District of Columbia* **Filing Company:** *New York Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Group Life Insurance Application*
Project Name/Number: */*

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Group Enrollment Form	GPA-A8.1	AEF	Initial			GPA-A8.1.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

MEMBER ENROLLMENT FORM

REQUEST FOR GROUP INSURANCE • AARP LEVEL BENEFIT TERM LIFE

AARP® Life Insurance Program from NEW YORK LIFE

New York Life Insurance Company
[5505 West Cypress • Tampa, FL 33607-1707]
newyorklifeforaarp.com

Please respond by: [Monthxxxx 00, 0000] [XXXX-XXX-XXX]

Please complete in ink — all sections must be complete to apply.

STEP 1 MEMBER ENROLLMENT

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(,) State Zip + 4]
AARP Membership No. [0000000000]

Social Security No: ___ - __ - ____ (Required)

Date of Birth: MM DD YY (Required) Gender: ☐ Male ☐ Female

Current Height: ☐ Feet ☐ Inches Current Weight: ☐ Pounds

In the past 12 months, have you used tobacco or nicotine in any form?
☐ Yes ☐ No

In the past 5 years, has your driver's license been suspended or revoked, have you been found guilty of impaired driving due to alcohol or drugs, or have you been incarcerated or convicted of a felony?
☐ Yes ☐ No Details ______________________

Coverage Amount Requested (please check only one coverage)

☐ $10,000 ☐ $20,000 ☐ $30,000
☐ $50,000 ☐ $100,000 ☐ $150,000

Daytime Phone #:

Email Address:

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name:

Relationship to You: Share:

Beneficiary Name:

Relationship to You: Share:

SPOUSE/PARTNER ENROLLMENT (can apply even if member does not)

First Name:

Last Name:

Social Security No: ___ - __ - ____ (Required)

Date of Birth: MM DD YY (Required) Gender: ☐ Male ☐ Female

Current Height: ☐ Feet ☐ Inches Current Weight: ☐ Pounds

In the past 12 months, have you used tobacco or nicotine in any form?
☐ Yes ☐ No

In the past 5 years, has your driver's license been suspended or revoked, have you been found guilty of impaired driving due to alcohol or drugs, or have you been incarcerated or convicted of a felony?
☐ Yes ☐ No Details ______________________

Coverage Amount Requested (please check only one coverage)

☐ $10,000 ☐ $20,000 ☐ $30,000
☐ $50,000 ☐ $100,000 ☐ $150,000

Daytime Phone #:

Email Address:

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name:

Relationship to You: Share:

Beneficiary Name:

Relationship to You: Share:

STEP 2 PAYMENT OPTIONS (choose one option)

1. ☐ **Bill me later.**
2. ☐ **I'll send my first payment now.** Make check payable to *AARP Life Insurance Program.*
3. ☐ **Deduct monthly premiums from my bank account.** Enclose a voided check.

CONTINUE ON BACK
Complete and sign back before mailing

STEP 3

STATEMENT OF HEALTH

Each applicant MUST check YES or NO for all 6 questions. Note: A YES answer does not automatically disqualify you.

	MEMBER	SPOUSE
1. In the past 5 years, have you had treatment or medication, received medical advice, or been diagnosed by a doctor or medical professional for heart trouble, stroke, cancer, diabetes, drug or alcohol abuse, lung, liver or kidney disease, or immune system disorder (excluding HIV or AIDS)? If you check YES, please circle the conditions above.	☐ YES ☐ NO	☐ YES ☐ NO
2. Has a doctor or medical professional recommended treatment or medication for, or diagnosed you with, HIV, AIDS or AIDS Related Complex?	☐ YES ☐ NO	☐ YES ☐ NO
3. In the past 5 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility, or have you received in home medical therapy or assistance?	☐ YES ☐ NO	☐ YES ☐ NO
4. In the past 12 months, have you seen a doctor or medical professional, or had treatment or diagnostic tests of any type (excluding negative HIV or AIDS tests)?	☐ YES ☐ NO	☐ YES ☐ NO
5. In the past 12 months, have you needed help from a person or device to independently walk, bathe, or dress?	☐ YES ☐ NO	☐ YES ☐ NO
6. In the past 12 months, have you taken or been prescribed any medications? If you check YES, please list below.	☐ YES ☐ NO	☐ YES ☐ NO

Please supply full details for health questions answered "Yes." List condition(s) and date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

MEMBER DETAILS:

SPOUSE DETAILS:

STEP 4

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? ☐ YES ☐ NO

I understand that insurance will be effective on the date of the certificate, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life ("NYL"). I will promptly notify the company in writing if, prior to the effective date of this certificate, I experience changes in my health that would render my answers to the above questions no longer true and complete. Answers that are not true and complete may cause benefits to be denied or may invalidate coverage. I represent that I am an AARP member, and that, to the best of my knowledge and belief, the information on this request is true and complete. **Note:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager, medical information retrieval service, or consumer reporting agency to release my medical information, my prescription drug history, my motor vehicle report, and other information to NYL, or its reinsurers, in connection with this life insurance. I authorize the release of my motor vehicle report by any consumer reporting agency to NYL or its reinsurers. I authorize MIB, Inc., or any insurance company to release information about me to NYL, or its reinsurers, in connection with this life insurance. I authorize NYL, or its reinsurers, to make a brief report about me to MIB. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 24 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I will receive a copy of this authorization.

X ______________________ __/__/__ X ______________________ __/__/__

[FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Today's Date Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Today's Date

[ ]

Supporting Document Schedules

Satisfied - Item:	Transmittal
Comments:	
Attachment(s):	Transmittal.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability
Comments:	
Attachment(s):	Readability Certification.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Explanation of Variability
Comments:	
Attachment(s):	GPA-A8.1 Explanation of Variability .pdf
Item Status:	
Status Date:	

Satisfied - Item:	Telephonic and Electronic Procedures
Comments:	
Attachment(s):	Complete Telephonic Application Procedures.pdf Electronic Signature Procedures.pdf
Item Status:	
Status Date:	

Reset Form

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	District Of Columbia

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	New York Life Insurance Company	NY	Life	0826	6915	13-5582869	FL

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Gina Babka 5505 West Cypress Street	813-288-5717	813-288-7411	gbabka@newyorklife.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): ____ ☐ Other (please explain): ____

6.	Company Tracking Number		
7.	☑ New Submission	☐ Resubmission	Previous file # ____
8.	Market	☐ Individual ☐ Franchise	
		Group	☐ Small ☑ Large ☐ Small and Large ☐ Employer ☑ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: ____
9.	Type of Insurance	**L08 Life-Other**	
10.	Product Coding Matrix Filing Code	**L08.000 Life-Other**	
11.	Submitted Documents	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☑ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: ____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☑ Statement of Variability ☑ Certifications ☐ Actuarial Memorandum ☐ Other____	

12.	**Filing Submission Date**	11/07/2016
13	**Filing Fee (If required)**	Amount ______ Check Date ______ Retaliatory ☐ Yes ☐ No Check Number ______
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	
	See filing.	

View Complete Filing Description

16.	**Certification (If required)**

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of ______________________________.

Print Name ______________________________ Title ______________________________

Signature______________________________ Date: ______________________________

LHTD-1, Page 2 of 2

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name / Description	Form Number		Replaced Form Number / Previous State Filing Number
01	Enrollment Form form	Form GPA-A8.1	☑ Initial ☐ Revised ☐ Other ____________	
02			☐ Initial ☐ Revised ☐ Other ____________	
03			☐ Initial ☐ Revised ☐ Other ____________	
04			☐ Initial ☐ Revised ☐ Other ____________	
05			☐ Initial ☐ Revised ☐ Other ____________	
06			☐ Initial ☐ Revised ☐ Other ____________	
07			☐ Initial ☐ Revised ☐ Other ____________	
08			☐ Initial ☐ Revised ☐ Other ____________	
09			☐ Initial ☐ Revised ☐ Other ____________	
10			☐ Initial ☐ Revised ☐ Other ____________	

LH FFA-1

18.	**Rate Filing Attachment**			
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			%	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐**Other ___________**	

LH RFA-1

READABILITY CERTIFICATION

Name Of Company: New York Life Insurance Company

Policy Form: Application GPA-A8.1

This is to certify for the state of New York that the forms listed on the attached page(s) attain the following readability criteria.

A. Option Selected

[ ] 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is ___.

[X] 2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated on the attached page(s).

B. Test Option Selected

[X] 1. Test was applied to entire policy form(s).

[ ] 2. Test was applied on a sample basis. Form(s) contain(s) more than 10,000 words. copy of form(s) enclosed indicating word samples tested.

C. Samples of Certification

A checked block indicates the standard has been achieved.

[X] 1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.

[X] 2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)

[X] 3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.

[X] 4. The section titles are captioned in bold face or otherwise stand out, significantly from the text.

[X] 5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.

[X] 6. The style, arrangement and overall appearance of the policy gives no undo prominence to any portion of the policy or to any endorsements or riders.

[X] 7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

Form #	Sentences	Words	Syllables	Flesch Score
GPA-A8.1	51	1101	1,718	52.9

Michael Horan

Michael Horan

Corporate Vice–President
Officer's Title

Date: November 7, 2016

Explanation Of Variable Fill-In For Forms GPA-A8.1
(Request For Group Insurance)

General

Form GPA-A8.1 is used to enroll for various Life Insurance products under the AARP Program for:

(a) initial or reinstated amounts of Life Insurance, and

(b) offerings to increase such amount (upgrades) after it is in force for 180 days when such increase is subject to underwriting requirements.

For both, initial and upgrade amounts, the form contains variable fill-in wording that is used solely within the nature and scope of this filing. The wording on the form is "boxed" to accommodate substantive differences between the various coverages, allow reinstatements, and facilitate administration of the Program, as well as format and/or cosmetic changes. The sections and their headings will appear substantially as shown or they may be omitted.

In the enclosed sample enrollment form some examples of variability are:

1. The header/title "Member Enrollment Form" may be replaced with "Member Reinstatement Form" if a member is applying for reinstatement. "Applicant" or another generic term may replace "Member". The portion above the header/title may contain directional copy such as "It is easy to apply. Just follow these simple instructions: 1. Complete and sign the form below. 2. Mail it in the postage-paid envelope provided" or "Apply Today! 1. Choose the coverage amount you need. 2. Complete all sections and sign the form. 3. Mail it in the postage-paid envelope provided. If you want coverage to take effect at the earliest possible date, include a check, payable to the AARP Life Insurance Program, for your first premium. Otherwise, send no money now."
2. The portions within the "Step 1. MEMBER ENROLLMENT" section and above are illustrative and reflect hypothetical personal information about the applicant, such as: the member/spouse name(s), address, date of birth, Social Security No., gender, etc. The tobacco user question and/or motor vehicle question may be deleted. Email Address may not appear. Height and weight may or may not be included.

   Reference to the name of the coverage will always refer to the coverage being offered. For example, "AARP Level Benefit Term Life" may refer to any other approved Life Insurance coverage. Also, the word "Upgrade" may follow the name of the coverage if the solicitation is for an increase in amount of insurance. When used for purposes other than initial issuance the title will reflect its purpose (i.e reinstatement…).
3. Under the Coverage Amount Requested within the section "Step 1. MEMBER ENROLLMENT", the various plan options generally appear as shown or the amounts of insurance and the number of choices of amounts may change. For example, the amounts may be higher or lower, or more or less amounts may be offered. The option of "other" with a blank line may also be included. These variables depend on marketing conditions, eligible issue ages, and/or underwriting practices. The beneficiary designation will appear as illustrated or it may be modified.
4. Under section "Step 2. PAYMENT OPTIONS", the billing options will appear as illustrated or modified to reflect other billing methods and/or frequencies that apply, or reference to automatic premium payment (electronic fund transfer) may be included.
5. "Step 3. STATEMENT OF HEALTH" section: Medical questions included in the enclosed examples are for an underwritten product. These questions may vary in order and/or format, such as question 1 may use check boxes rather than listing conditions in a series separated by commas. Please note, the intent of the questions will not change with any revision.

For non-underwritten products the health questions will be omitted.

6. The “Step 4. READ AND SIGN BELOW” section generally appears as shown for coverage that requires medical underwriting.

   For a coverage that does not require medical underwriting the agreement section may read as demonstrated below:

   [I understand that insurance will be effective on the date of the certificate, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that I am an AARP member, and that, to the best of my knowledge and belief, the information on this request is true and complete. **I understand that this coverage is issued without medical underwriting; the premium rate being charged includes an extra mortality risk charge**. **Note:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.]

   For the addition of a rider the agreement section may read as demonstrated below:

   [I understand that insurance coverage will begin on the effective date of coverage as stated in the Rider, if my premium is received within 31 days of such date. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the effective date. I am an AARP member and, to the best of my knowledge and belief, the information on this request is true and complete.]

   For reinstatement of coverage the agreement section may read as demonstrated below:

   [I understand that (a) premium payment for reinstatement of insurance does not mean there is any coverage in force, (b) reinstatement of this insurance will not take effect until the date the insurer approves this request, and the amount due is received within the lifetime of the insured, (c) benefits may be denied during the first two years after reinstatement of this insurance if material facts have been misstated here and (d) choice of billing method, beneficiary designations and frequency of payment will remain the same as previously selected. I represent to the best of my knowledge and belief, the information on this request is true and complete.] This section may include additional signature lines for different owner/insured.

   For reclassification of risk class the agreement section may read as demonstrated below:

   I understand that insurance will be effective on the date of the certificate, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life (“NYL”). I understand existing coverage for which I have requested reclassification will be terminated upon issuance of the new reclassified coverage. If material facts have been misstated here, benefits may be denied if the insured’s death occurs within the first two years after the Insurance Date. I represent that I am an AARP member, and that, to the best of my knowledge and belief, the information on this request is true and complete.

   For lower coverage amounts the Rx authorization section may be deleted.

7. If the jurisdiction in which the applicant is a resident does not require a fraud statement to be disclosed, the fraud statement (“Note”) will be deleted or amended to comply with state requirements.

8. If coverage is only offered to the member all references to “spouse/partner” and the distinction need for “member” will be removed. If a single page approach is used (front only), the current information may be condensed or reordered to fit within one page in both instances where coverage is offered to both the member and spouse or just the member. If a “Front/Back” approach is used where the member portion is on the front only and the spouse/partner portion is on the back, the reverse side of the form will include the same information used for the “spouse/partner” except that: (a) reference to “Member Enrollment Form” at the top of the reverse side is changed to read “Spouse/Partner Enrollment Form”, and (b) reference to, “SPOUSE/PARTNER ENROLLMENT FORM ON REVERSE SIDE” appears at the bottom of the front side of the form. The current information may be reordered to accommodate the format.

New York Life certifies that all of the changes to the enclosed example of Form GPA-A8.1 will be in compliance with state laws and will be within the scope and nature of the variations described above.

Telephonic Application with Marketing Material Procedure

When an individual receives a marketing kit that includes an application, they have the option to call us to apply over the phone. Once the call is received regarding an application over the phone, several verification items are required; the customer is required to have the application form at the time they call, and they have to provide the control number, Social Security Number and/or Date of Birth.

The customer service representative will proceed to read all disclosures and ask all questions verbatim from the application. If the customer answers ”Yes” to any of the health questions, they are instructed to complete the paper application they have, sign it and mail it in. If all health questions are answered “No”, the personal information provided by applicant is validated using a SSN database, once validated the application is then submitted for final approval.

The applicant will be read the agreement and authorization section of the application and provide a voice signature.

When the certificate is issued, it will include a copy of the completed application, electronically signed.

The recording of this transaction is saved in our systems for 8 years.

Telephonic Applications without Marketing Material

Consumers who approach New York Life through any of our media channels or those who directly contact our call center can be offered the opportunity to complete an application over the phone.

Once the call is received and if the consumer is interested in purchasing coverage a licensed representative will provide product specific information. A rate quote will be given to the consumer based upon coverage amount, age, gender & state. The representative will provide complete “invitation to contract” product details to the consumer. If the consumer decides to move forward with submitting an application over the phone, the representative will collect all necessary information that is required on the application. New York Life will obtain personal information including name, address, date of birth, and social security number that will be validated through authentication processing to help ensure the applicant’s identity. This information is used for authentication and issuance of coverage. The representative will read the agreement and authorization section of the application and ask the consumer to provide their consent for a voice signature.

When the contract is issued, it will include a copy of the completed application that will be signed using an electronically signed stamp. As with all of our products the consumer has a 30 day free look provision in which the policy may be returned for any reason.

Electronic Signature
Procedure

An individual can request information about our products via our program website. The caller will be offered the opportunity to complete the application process online or receive a fulfillment kit.

If the customer wishes to apply online, several verification items are required; the customer is required to provide the address, Social Security Number and/or Date of Birth.

If the customer answers "Yes" to any of the health questions, they are instructed to enter details.

The applicant will be shown the entire application, including the agreement and authorization section of and be asked to submit their electronically signed application.

Applicant information is then verified using a SSN database.

The application is then submitted for final approval.

When the policy is issued, it will include a copy of the completed application, electronically signed. The recording of this transaction is saved in our systems for 8 years.